Primary Care Plan Update 2017
Refuah Community Health Collaborative
September 29, 2017

Introduction

The New York State (NYS) Delivery System Reform Incentive Payment (DSRIP) Program´s purpose is to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25 percent by 2020. To transform the system, the DSRIP Program focuses on the provision of high quality, integrated primary, specialty, and behavioral health care in the community setting, with hospitals used primarily for emergent and tertiary levels of service. The integration of services and the path to value-based care puts primary care at the center of the health care delivery system. Primary care is the cornerstone of the DSRIP Program and is critical to NY State's success in the overall improvement and coordination of health care.

Instructions

The DSRIP Primary Care Plan Update is an opportunity for each PPS to highlight, and inform the New York State Department of Health (the Department) and the DSRIP Project Approval and Oversight Panel (PAOP) of, progress towards and challenges to the improvement of Primary Care under the DSRIP program.

For each fundamental, the PPS is asked to provide a series of brief updates in the space provided (approximately 250 words) to questions under each fundamental in its final Primary Care Plan submitted in 2016. The PPS should reference its previously submitted Primary Care Plan when completing this Update. Completion of the Primary Care Plan Update includes the progress the PPS has made within a fundamental, an outline of any challenges related to implementing the Primary Care Plan strategies, an explanation of any changes that need to be made to the Primary Care Plan, and other related questions where applicable. The Department requests that the PPS be as concise as possible in its responses; where elements are not relevant to their Primary Care Plan, 'N/A' should be written. Under fundamentals where no strategic changes have been made, please describe how the PPS' initial strategies continue to support that fundamental. Throughout the Update, some fields have been auto-populated for the PPS' convenience based on figures available to the DSRIP team. The Department requests that the PPS review these fields for accuracy and make revisions where necessary. The completed template is **due September 29, 2017** to the DSRIP Team at dsrip@health.ny.gov with subject line: 'Primary Care Plan Update'.

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Primary Care Plan Overall Strategic Updates

- Overall PPS strategic changes impacting the Primary Care Plan

a. From April 1, 2016 to March 31, 2017, describe any overall strategic changes the PPS has made and the impact of these changes on the PPS' final Primary Care Plan submitted in 2016.

RCHC's overall primary care strategy remains fundamentally unchanged. RCHC remains committed to bolstering and expanding the capacity and services of its FQHCs in order to expand its primary care network. Specifically, RCHC is committed to enlarging its FQHC and primary care capacity and scope of services in a targeted manner which will reduce the demand for ER/inpatient services, (e.g. infusions, suturing, setting fractures, monitoring for longer periods, after hours services, etc.)

Fundamental 1: Assessment of current primary care capacity, performance and needs, and a plan for addressing those needs.

- PPS' over-arching approach for expanding Primary Care capacity and ensuring the provision of required services (including, as appropriate, addressing gaps in Primary Care capacity)
- How is the PPS working with community-based Primary Care Practitioners (PCPs), as well as institution-based PCPs?

a. Describe the PPS' progress in addressing primary care capacity and needs from April 1, 2016 to March 31, 2017. Include efforts to extend hours and increase access to primary care services:

Refuah Health Center began construction on new additional floors to expand adult and pediatric primary care services. The construction will be completed in Fall/Winter of 2017 and is projected to serve 5,000 – 7,000 new patients. Refuah Health Center already operates the longest hours of any FQHC in the country, with services available to patients until after mid-night most nights of the week.

This construction project will provide Refuah with expanded capacity to diagnose and treat BH issues, as the new physical space will allow Refuah to embed trained BH proviers within primary care. This in turn will provide primary care providers with the proper support necessary to foster the provision of high-quality integrated BH/primary care services.

Cornerstone Family Health Center acquired Jawonio's primary care location in Rockland County. This change in control will allow the New City site to leverage Cornerstone's existing infrastructure and enhance the provision of primary care services to patients in Rockland County.

b. Describe the PPS' challenges from April 1, 2016 to March 31, 2017 with addressing primary care capacity needs:

Although RCHC has made progress in expanding its already robust primary care network, challenges remain. In particular, the national shortage of primary care providers continues to pose difficulties to building additional primary care capacity. However, RCHC primary care sites are actively working to recruit primary care providers, and are having success, particularly with respect to the recruitment of nurse practitioners. For example, Refuah Health Center has recruited and successfully hired 7 nurse practitioners since the beginning of the DSRIP program.

c. Based on the PPS' progress and challenges addressing Fundamental 1 from April 1, 2016 to March 31, 2017, what strategic changes have been made to Fundamental 1 outlined in the final Primary Care Plan submitted in 2016?

While continuing to promote a "top-of-the-license" approach, RCHC has supplemented its primary care workforce strategy by focusing on the recruitment of mid-level providers. RCHC has found that mid-level providers are easier to recruit and provide a cost-effective care option.

In addition to the initatives described in its original plan, RCHC is pursuing a series of tactics to provide additional support to primary care providers in order to reduce provider "burn-out" and allow practitioners to focus more directly on patient care. In particular, the following steps are being implemented: a) patient services staff has been expanded and tasked with all outreach and clerical work; b) the use of medical scribes; c) training nurses to provide depression screenings; d) embedding social workers and promoting "warm hand offs" for patients at risk for depression; e) hiring care managers.

d. Describe what the PPS has done from April 1, 2016 to March 31, 2017 to engage community-based Primary Care Providers:	
As noted in the original Primary Care Plan, RCHC's PCP network does not include any private-practice PCPs. RCHC believes that the most effective way to institute transformation is through growing its network of FQHC-based providers. It is RCHC's philosophy that FQHCs are community-based primary care providers. RCHC's strategy is supported by a November 2016 study in the American Journal of Public Health that found that Medicaid enrollees receiving services at FQHCs had lower utilization and spending than non-health center patients across all services, with 22% fewer visits, 33% lower spending on specialty care, 25% fewer admissions and 27% lower spending on inpatient care. Overall, total spending for FQHC patients was found to be 24% lower than for non-FQHC patinets. Thus far, this strategy appears to be effective; however, RCHC will continue to evaluate opportunities to collaborate with private practice PCPs and update its network as appropriate.	
Number of Engaged Primary Care Practitioners in Community-Based Practices as of March 31, 2017:	0

e. Additional Information

Number of Primary Care Practitioners in the PPS-defined Network who are eligible for National Center for Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) or Advanced Primary Care (APC) as of March 31, 2017:	103
Number of Primary Care Practitioners in the PPS-defined Network who are NCQA PCMH 2014 Level 3 recognized as of March 31, 2017:	97
Number of Primary Care Practitioners in the PPS-defined Network who are pursuing APC recognition as of March 31, 2017:	0

Fundamental 2: How will primary care expansion and practice and workforce transformation be supported with training and technical assistance?

- What are your PPS plans for working with Primary Care at the practice level, and how are you supporting practices to successfully achieve PCMH or APC recognition? (Resources could include collaboration, accreditation, incentives, training and staffing support, practice transformation support, central resources, vendors to support key activities, additional staffing resources, etc.)
- How is your PPS working to ensure that existing statewide resources for technical assistance are being leveraged appropriately?

a.   From April 1, 2016 to March 31, 2017, describe the PPS' progress in working with primary care practices to meet NCQA PCMH 2014 Level 3 or APC milestones:

All of RCHC's FQHC providers are PCMH Level 3 certified. With respect to Bon Secours Medical Group, all but 4 of its primary care providers are PCMH certified, half of whom have already submitted applications to NCQA. The Bon Secours practice is affiliated with Westchester Medical Center. WMC and RCHC have the same timeline for PCMH certification. RCHC has been monitoring Bon Secours progress and believes that the remaining providers will obtain PCMH certification in a timely manner.

Jawonio is no longer eligible for PCMH certification as their Article 28 practice was acquired by Cornerstone Family Health.

b. From April 1, 2016 to March 31, 2017, describe the PPS' challenges in working with primary care practices to meet NCQA PCMH 2014 Level 3 or APC milestones:

All of RCHC's FQHCs were PCMH Level 3 certified as of the date of submission of the Primary Care Plan. Four primary care providers in RCHC's network remain, half of whom have already submitted their applications. As noted above, the Bon Secours providers are on track to obtain certification in a timely manner.

RCHC has received feedback from its primary care providers that they have found certain PCMH requirements unnecessarily cumbersome and inefficient. Some providers also found that they underestimated staffing needs to monitor and maintain compliance with PCMH standards. However, RCHC has not found these concerns to be actual barriers to PCMH implementation.

c. Based on the PPS' progress and challenges addressing Fundamental 2 from April 1, 2016 to March 31, 2017, what strategic changes have been made to Fundamental 2 outlined in the final Primary Care Plan submitted in 2016?

As noted above, the vast majority of RCHC's primary care providers were PCMH-certified prior to the submission of the Primary Care Plan. RCHC's PCMH strategy remains unchanged.

RCHC has found that peer-to-peer support has been the most effective method to support PCMH transformation. RCHC found that putting partners in touch with one another as a support resource, without necessarily having the lead agency or other entity dictate or direct the PCMH process, is highly effective. This approach respects the individual identity of each organization and allows growth and change to happen organically.

e. Additional Questions:

Is the PPS contracting with any vendor(s) for PCMH recognition assistance? ☐Yes ☒No

Number of Primary Care Practitioners who have or are receiving vendor support for PCMH recognition from vendors contracted by the PPS as of March 31, 2017:	0
Number of Primary Care Practitioners who have or are receiving vendor support for PCMH recognition from outside the PPS contracted vendors as of March 31, 2017:	0

Is the PPS contracting with any vendor(s) for electronic health record (EHR) transformation assistance?
☐Yes ☒No

Fundamental 3: What is the PPS' strategy for how primary care will play a central role in an integrated delivery system?	
• How will the PPS strengthen the continuum of Primary Care and ensure meaningful linkages to necessary secondary and tertiary services? • How is Primary Care represented in your PPS' governance committees and structure, and your clinical quality committees?	
Number of Engaged Primary Care Practitioners	164

a. From April 1, 2016 to March 31, 2017, describe the PPS' progress towards implementing an integrated delivery system with Primary Care playing a central role. Be sure you address efforts to strengthen the continuum of Primary Care and ensure meaningful linkages to necessary secondary and tertiary services:

RCHC's IDS strategy involves the creation and expansion of integrated primary care hubs, i.e., primary care location providing integrated medical and behavioral health care supported by robust care coordination. In furtherance of this goal, RCHC partners have expanded their care management, case management and patient navigation services. Namely, partners have hired 21 additional FTEs to provide these services. To date, all partner hospitals are connected to the RHIO; consent training has occurred at 16 partner sites. RCHC provided agreements to 38 eligible provider organizations offering financial incentives from $50,000-$100,000 (depending on the number of applicable integration requirements) --- 27 such agreements have been signed.

RCHC is also piloting a hospital-FQHC liaison program which is intended to provide RCHC's primary care providers with greater integration with its patients' inpatient services in order to coordinate care and facilitate better discharge planning so as to avoid unnecessary readmissions.

Additionally, RCHC is engaging with specialists both within and outside of its PPS network to incentivize these providers to move away from fax and switch to a single DIRECT messaging mailbox via Healthlinkny to ensure more secure communications.

b. From April 1, 2016 to March 31, 2017, describe the PPS' challenges in implementing an integrated delivery system with Primary Care playing a central role:

As an FQHC-centered PPS, RCHC is primary care led and primary care driven. RCHC has made significant progress in integrating the delivery system around primary care. Challenges to this process have included: 1) Limited EMR/RHIO vendor availability; 2) obtaining meaningful data in order to inform strategic decision making. Specifically, RCHC has found that its biggest risk is vendor capacity. Not all systems can accommodate "data out." There is a lack of standardization and capabilities from EMR vendors, and certain EMRs offer products similar to the HIE and therefore are not motivated to facilitate connection. Moreover, the regional RHIO, Healthlinkny, has had limited bandwidth to implement connections and has prioritized hospitals over FQHCs/primary care providers. Hospital delays in bidirectional information exchange with the RHIOs have resulted in limited utility for PCPs, even when they are connected; thus, PCPs receive information that is not valuable or actionable, which risks that the use of the RHIO is abandoned. RCHC has found that its primary care providers very much desire to utilize the RHIO in theory, but it has yet to provide meaningful information. Furthermore, the costs of connection have proven high for some partners, which RCHC has sought to alleviate through its funds flow model. Additionally, OMH and OASAS have not been permitted to upload data to the RHIO via the interfaces and no mechanism exists by which to tailor consent to partially exclude certain information. RCHC is addressing these challenges by: 1) including provisions in its VPB contract that requires the MCO to share data in a useable format (e.g. Fidelis 3M dashboard); and 2) RCHC is working directly with Azara to create an analytics tool that can incorporate both MCO claims data and real-time EMR data.

c. Based on the PPS' progress and challenges addressing Fundamental 3 from April 1, 2016 to March 31, 2017, what strategic changes have been made to Fundamental 3 outlined in the final Primary Care Plan submitted in 2016?

RCHC offered incentive payments of $100,000 to each of its primary care organizations to promote the 8 distinct integration/connectivity/data exchange goals.

d. From April 1, 2016 to March 31, 2017, describe what the PPS has done to assist primary care practices with implementing EHRs and reaching Meaningful Use Stage 2:

All of RCHC's primary care practices had EMRs in place at the time of the original plan. However, in order to achieve meaningful use, primary care providers need to have DIRECT messaging with the specialists to whom they refer. RCHC has found that many specialists prefer to use fax rather than DIRECT messaging. RCHC is conducting outreach to specialists and will be offering incentives for switching to a single DIRECT messaging mailbox via Healthlinkny.

e. From April 1, 2016 to March 31, 2017, describe what the PPS has done to assist primary care practices to connect to Regional Health Information Organizations (RHIO)/Qualified Entities (QE) and the State Health Information Network of New York (SHIN-NY):

RCHC has offered all of its PPS partners one-time infrastructure payments in order to assist partners with connecting to the RHIO. RCHC has made progress towards meeting all connectivity requirements and is actively monitoring and assisting its partners towards achieving full connectivity.

Number of Primary Care Practitioners connected to RHIO/QE as of March 31, 2017:	137

f. Additional Information

Number (percentage) of Primary Care Practitioners engaged in PPS governance as of March 31, 2017:	12, 48%
Number (percentage) of Primary Care Practitioners engaged in PPS governance that are institution-based as of March 31, 2017:	1, 4%
Number (percentage) of Primary Care Practitioners engaged in PPS governance that are community-based as of March 31, 2017:	11, 44%

Fundamental 4: What is the PPS' strategy to enable primary care to participate effectively in value-based payments?

- How will key issues for shifting to Value-Based Payment (VBP) be managed? (e.g. technical assistance on contracting and data analysis, ensuring primary care providers receive necessary data from hospitals and emergency departments (EDs), creating transition plans, addressing workforce needs and integrating behavioral health)

a. From April 1, 2016 to March 31, 2017, describe the PPS' progress towards VBP Readiness in primary care as determined by the PPS' VBP Needs Assessment and VBP Support Implementation Plan:

RCHC actively worked on the development of a population health tool with Azara that will allow the PPS to engage in enhanced data-sharing with MCOs. All network FQHCs have entered into VBP Level 1 contracts with MCOs. RCHC has begun to develop additional VBP training programs for its partners, providers and CBOs.

A key to RCHC's VBP strategy is the integration of behavioral health into primary care. In this regard, RCHC has begun to operationalize the AIMs model of behavioral health integration, as well as insfrastructure changes to ensure that BH providers are imbedded in primary care practices.

Further, RCHC is piloting a hospital-FQHC liaison program which is intended to provide RCHC's inpatient and outpatient care teams seamless communication enabling better discharge planning so as to avoid unnecessary readmissions. The hospital liaison has access to both hospital and FQHC EMRs and case managers.

Refuah Health Center is participating in a MAX series on maximizing the care that can be provided in the ambulatory setting. The goal of this program is to allow patients to spend as much time as possible in a primary care setting, and to ensure that the PPS's primary care networks or hubs are not "leaking" patients outside of the network in a manner that results in decreased quality of care and uncontrollable costs.

b. From April 1, 2016 to March 31, 2017, describe the PPS' challenges in working towards VBP Readiness among the PPS' primary care providers:

The main challenge RCHC has experienced with respect to VBP readiness is obtaining hospital data and MCO cost data. RCHC has also found that even its primary care partners are not sharing detailed information on VBP contracting. Overall, RCHC has found an industry-wide hesitation to share data and collaborate on VBP initiatives.

c. Based on the PPS' progress and challenges addressing Fundamental 4 from April 1, 2016 to March 31, 2017, what strategic changes have been made to Fundamental 4 outlined in the final Primary Care Plan submitted in 2016?

The main change to RCHC's strategy has resulted from the fact that the PPS, itself, is not a contracting entity for VBP. Thus, RCHC has found itself in the role of a facilitator, serving as a resource for its partners who are contracting entities, or plan on being contracting entities.

Further, because RCHC recognizes the key role that CBOs (i.e., social determinants of health) will play under VBP, RCHC has initiated programs that work on educating CBOs to be able to communicate their value to VBP contracting entities.

d. From April 1, 2016 to March 31, 2017, describe what the PPS has done to support Primary Care providers to engage Managed Care Organizations (MCOs) for VBP contracting:

The majority of RCHC's FQHC partners have entered into VBP contracts – as a result over 89% of RCHC's attributable lives are now part of a VBP plan.

RCHC does not have any providers currently in level 2 or 3 VBP arrangements although some agreements will convert to level 2 in subsequent years. RCHC is supporting partner growth towards this goal by developing the Azara population health tool that will allow FQHCs to engage in enhanced data-sharing with the MCOs. RCHC has also partnered with CBOs in order to bridge the gap – most notably, RCHC has entered into a series of arrangements with Konbit Neg Lakay, Haitian-American community organization, in order to ensure that patients have access to services such as diabetes self-management classes, on-demand transportation services for primary care and behavioral health services, and many other social service supports, with the hope that patients will feel comfortable to avail themselves of those services due to the culturally sensitive nature in which they are administered.

RCHC is also involved in a number of outreach intiatives with multidisciplinary team building and break out groups intended to foster a better connection between CBOs, mental health, and primary care providers.

f. Additional Questions

Is the PPS planning to form a contracting entity (e.g. ACO Certificate of Authority)? ☐Yes ☒No ☐N/A

…If yes, has it been granted? ☐Yes ☐No

Has the PPS provided technical assistance to primary care partners planning to form a contracting entity (e.g. ACO or IPA)? ☐Yes ☒No

…If yes, describe: Click or tap here to enter text.

Fundamental 5: How does your PPS' funds flow support your Primary Care strategies?

- What resources are being expended by your PPS to support PCPs in DSRIP?

a. Describe how the funds flow model(s) support(s) primary care in the PPS network:

RCHC has developed a funds flow model which ensures that appropriate partner distributions are made in order to meet its project goals and expand primary care capacity. As an FQHC-centered PPS, with a strong existing primary care base, RCHC directs its funds flow towards the expansion of primary care through implementation of the projects and related infrastructure initiatives. Specifically, RCHC flows funds as follows:
1.   Project Infrastructure & Requirements
2.   Patient Engagement
3.   Attribution & Performance

Specific examples include: a) in connection with Project 2.a.i, offering primary care providers up to $100,000 for achieving the 8 elements of clinical integration using the RHIO; b) in connection with Project 2.c.i, offering eligible partners $7.50 per patient navigated; and c) in connection with Project 3.a.i, primary care sites are compensated for demonstrated BH integration.

b. Funds Flow	Total Dollars Through DY2Q4	Percentage of Total Funds Flowed
Total Funds Distributed	$6,771,143.88	**100%**
Primary Care Provider	$3,494,592.00	51.6%
Hospital-Ambulatory Care	$6,000.00	0.1%
Federally Qualified Health Centers (FQHCs)	$3,457,067.00	51.1%
Primary Care Practitioners	$31,525.00	0.5%
PMO Spending to support Primary Care	$607,819.83	9.0%

c. Based on the PPS' progress and challenges addressing DSRIP performance from April 1, 2016 to March 31, 2017, what strategic changes have been made to the funds flow model outlined in the final Primary Care Plan submitted in 2016?

RCHC is in the process of developing a 4th funds flow model, which will be a performance-based model. Attributed lives will be matched against the state's list of patients who met performance measures during a given period. Partners will then be rewarded or penalized for a specific patient depending on whether or not the specific patient met a given measure.

d. Additional Questions

From April 1, 2016 to March 31, 2017, did the PPS distribute payments for achieving PCMH or APC recognition? ☒Yes ☐No

From April 1, 2016 to March 31, 2017, did the PPS distribute payments for achieving defined performance measurement targets? ☐Yes ☒No

Fundamental 6: How is the PPS progressing toward integrating Primary Care and Behavioral Health (BH) (building beyond what is reported for Project 3.a.i. within the quarterly report)?

- Including both collaborative care and the development of needed community-based providers.

a. From April 1, 2016 to March 31, 2017, describe the PPS' progress towards integrating Primary Care and Behavioral Health (building beyond what is reported for Project 3.a.i. within the quarterly report):

Several RCHC partners have expanded beyond the typical co-location model and have achieved a higher level of integration with seamless warm hand offs, the development of patient-specific teams consisting of consultative psychiatrists, therapists, care managers and primary care providers/nurses, and routine screenings for every patient. In particular, LCSW, LMSW, PsyD, psychiatirista and RN care coordinators with training/experience in BH (e.g. motivational interviewing) are being imbedded into PCP practices. RCHC has also leveraged telepsychiatry for those complex cases that require the direct care by a psychiatrist, and concurrently has implemented IT tracking and outreach systems so that patients are no longer lost to follow up. These initiatives have greatly expanded the capacity of RCHC's two integrated primary care sites to deliver high quality BH care with no waiting list, as well as provided more convenient and timely treatment for individuals and the population as a whole.

RCHC is also involved in several related initiatives which will span beyond the completion of Project 3ai, namely RCHC is actively pursuing the launch of a substance abuse treatment program in South Fallsburg. Additionally, RCHC is supporting a Rockland County Article 31 facility as an Certified Community Behavioral Health Clinic demonstration site. RCHC believes that healthcare is in the midst of a cultural shift that now views BH and primary care as inextricably interconnected, and that integrated models will be the norm going forward. Moreover, the nationwide shortage of psychiatrists has essentially forced integration, and backsliding to prior models is unlikely.

b. From April 1, 2016 to March 31, 2017, describe the PPS' challenges to integrating Primary Care and Behavioral Health (not including regulatory issues):

RCHC established a Model 2 site at St. Christopher's Inn, which hired a primary care NP. However, over the term of the arrangement, as an OASAS provider, St. Christopher's Inn found that their clients had very few unaddressed primary care needs. The patient were already receiving primary care (e.g. HIV+ patients who already had an ID specialist caring for them) or the patients were relatively young and healthy with screenings identifying very little need for additional follow-up care. St. Christopher's did not see the value of continuing to provide primary care within their existing location.

RCHC has found that Model 1 integration to be much more effective at improving outcomes.

c. From April 1, 2016 to March 31, 2017, describe the PPS' challenges to integrating Primary Care and Behavioral Health specific to regulatory issues:

RCHC has experienced regulatory issues with respect to the implementation of its telemedicine program. Specifically, RCHC has encountered issues with billing for telemedicine services, including telepsychiatry. It is RCHC's understanding that these concerns are in the process of being addressed by the state through the Regulatory Modernization Initiative.

RCHC has also encountered regulatory roadblocks in attempting to set up telemedicine arrangements with Article 31 clinics. Due to the restrictions on the provision of telehealth services to patients in an Article 31 facility, RCHC has found it difficult to set up "spoke" or "distant" services as these sites are required to be OMH certified. This rules out the possibility of a patient in an Article 31 provider remotely accessing a psychiatrist or similar provider if such provider is physically located in an Article 28 facility, or in the provider's home. This regulation has proven to be a barrier to facilitating meaningful access to psychiatric services.

d. Based on the PPS' progress and challenges addressing Fundamental 6 from April 1, 2016 to March 31, 2017, what strategic changes have been made to Fundamental 6 outlined in the final Primary Care Plan submitted in 2016?

RCHC has not made any changes to its strategy, but notes that it has experienced such a positive effect from its initial integration efforts with major depressive disorder, ADHD and anxiety that RCHC participating partners are now expanding their efforts into women's health, particularly with post partum depression, and into the area of substance abuse.

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e. Model	Number of Sites Planned	Number In Progress	Number Complete
Model 1	2	2	2
Model 2	1	1	1
Model 3 IMPACT	0	0	0

f.   Please check all trainings that the PPS provides directly, or supports partners in delivering, to Primary Care Providers for Behavioral Health Integration within DSRIP projects from April 1, 2016 to March 31, 2017:

⊠Alcohol Use screening
⊠ Billing for Integrated Care
⊠ Collaborative Care for Depression, i.e. IMPACT model
⊠ Depression screening
⊠ EHR Integration
☐ Health Homes
☐ Medication Assisted Treatment (MAT) e.g. for Opioid Use Disorder or Alcohol Dependence
⊠ Mental Health First Aid
⊠ Outcomes Measurement
⊠ Patient Consent and Privacy regulations specific to Behavioral Health populations
⊠ Person-Centered Care
⊠ Peer Services
⊠ Population Health
⊠ PSYCKES
⊠ Quality Improvement Processes
⊠ Regulatory Issues
☐ Screening, Brief Intervention, and Referral to Treatment (SBIRT)
⊠ Serious Mental Illness
⊠ Tobacco Cessation
⊠ Trauma Informed Care
☐ Other Mental Health screening (please specify): Click or tap here to enter text.
☐ Other Substance Use screening (please specify): Click or tap here to enter text.
☐ Other
   Describe:
   Click or tap here to enter text.

GLOSSARY OF TERMS

Community-Based Primary Care Practitioner/Provider/Practice: A practitioner/provider/practice servicing primary care that is not employed by a hospital or hospital-system

Engaged Provider: Providers reported in PIT/PIT-Replacement as engaged on at least one project

Institution-Based Primary Care Practitioner/Provider/Practice: A practitioner/provider/practice servicing primary care that is employed by a hospital or hospital-system

PPS-defined Network: Provider Network in the MAPP DSRIP PPS Network Tool filtered to Practitioner-Primary Care Provider (PCP) for Provider Category or PPS-defined Provider Category

Primary Care Practice: Individual sites providing primary care services

Primary Care Practitioner (PCP): Individual practitioner providing primary care services

Primary Care Provider: Entity providing primary care services

RHIO/QE Connectivity: Providers sharing data with RHIO/QE or have an active BAA in place with the RHIO/QE